KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES
HEALTH OCCUPATIONS CREDENTIALING

APPLICATION FOR ADULT CARE HOME OPERATOR REGISTRATION

K.S.A. 39-923 outlines requirements for obtaining Kansas Registration. Please review the statutes.

The three options for obtaining registration are briefly described below and impact how this application form is completed.
Please circle the option under which you are applying for registration.

Option A Possess a Baccalaureate degree in any area of study
Option B Possess an Associate's degree in a relevant field as determined by the Secretary
Option C Possess a high school diploma or equivalent, with one year relevant experience as determined by the Secretary

REGISTRATION FEES

******Fees pro-rated for partial year licenses. Enclose non-refundable fee: **Payable to KDADS**. Personal checks are accepted. Visa or Master Card may be used for payment of fees. Credit Card Authorization Form must be completed and signed to utilize this option.

Operator Registration: $65

APPLICANT INFORMATION

(All applicants must complete this section)

Name:_____
Last First Mi Other

Address:_____
Street / Route / Box / Apt # City State Zip

Email: _____

Birthdate:_____ SSN_____

Phone: work _____ home _____ cell _____

(attach a copy of your Social Security Card or document bearing your name and Social Security number)

COLLEGE EDUCATION

(Applies to applicants using Option **A** or **B**)

Transcripts must be sent by the college or university directly to Health Occupations Credentialing.

	College/University	Degree	Date Conferred
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

HIGH SCHOOL DIPLOMA OR EQUIVALENT

(Applies to applicants using Option C)

Verification of high school diploma or equivalent must accompany this application.

WORK EXPERIENCE
(Applies to applicants using Option C)

Please list the Employer(s), your job title(s), and employments date(s) below for the work experience being utilized to meet the requirement of **ONE YEAR** relevant experience. **VERIFICATION** of the work experience is also required.

_____

_____

_____

DISCIPLINARY ACTION/CONVICTIONS
(Applies to all applicants)

Pursuant to K.S.A. 39-923, has disciplinary action ever been taken against an Operator credential or a professional or occupational health care license held by you, whether issued by this state or another state or jurisdiction and/or have you had a finding of Abuse, Neglect or Exploitation against a resident of an adult care home as defined in K.S.A. 39-1401 and amendments thereto?

Please Circle: YES NO

If YES, please provide specific details and copies of all relevant documents.

Pursuant to K.S. A. 39-923, have you ever been convicted of a crime by any court (including Kansas), or any federal court of the United States? This includes any felony, misdemeanor, or DUI convictions.

Please Circle: YES NO

If YES, please indicate:

Date of Conviction: _____

City, County, and State of Conviction: _____

Crime of which Convicted: _____

NOTE: Candidate shall provide all reports and court documents related to the conviction. The candidate shall have the burden of proving the candidate has been rehabilitated and warrants the public trust.

I do hereby attest that the information supplied in this application and any attachment is accurate and complete to the best of my knowledge. I do hereby give permission to the agency to verify any information provided in this application and attachments.

_____ _____

SIGNATURE OF APPLICANT **DATE**

PLEASE NOTE: Your signature must be notarized

SUBSCRIBED AND SWORN TO before me, the undersigned authority, on this

_____ day of _____ 20_____

_____
(Notary Public)

My appointment expires: _____

HEALTH OCCUPATIONS CREDENTIALING
612 S KANSAS AVE TOPEKA KS 66603
Adult Care Home
OPERATOR
CRIMINAL RECORD CHECK REQUEST

LAST NAME _____ FIRST NAME _____ MIDDLE NAME _____ SUFFIX _____

OTHER LAST NAMES EVER USED: _____

_____

_____

SOCIAL SECURITY NUMBER _____ DATE OF BIRTH _____

GENDER _____

ONE OF THE FOLLOWING MUST BE SELECTED
A – ASIAN OR PACIFIC ISLANDER
B – BLACK
I – NATIVE AMERICAN/ALASKAN NATIVE
W - WHITE

RACE_____

ADDRESS _____ PO BOX (IF APPLICABLE) _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____

CELL PHONE _____

WORK PHONE _____

KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES
SURVEY, CERTIFICATION AND CREDENTIALING COMMISSION
HEALTH OCCUPATIONS CREDENTIALING

CREDIT CARD AUTHORIZATION FOR VISA OR MASTERCARD

This charge is for: _____
Please Print Facility Name / Name of individual for Certification or Licensing

As payment of fees for:

SELECT APPROPRIATE OPTION

Certification

Course #: _____

_____ Certified Nurse Aide
_____ Certified Home Health Aide
_____ Certified Medication Aide
_____ Reschedule State Test

$ _____ Fee amount paid

Criminal Record Check

Number of names checked: _____ x $10.00 per name = $ _____ Total paid

Licensing

Credential # _____ Speech-Language Pathology
_____ Audiology
_____ Dietitian
_____ Adult Care Home Administrator
_____ Operator Registration

$ _____ Fee amount paid

Credit Card company service fee of 3.04% will be added to the total

VISA Card number (required) _____

Expiration Date (required) _____

OR

MASTERCARD Number (required) _____

Expiration Date (required) _____

_____ _____
Name of Cardholder (required) Signature (required)

FOR OFFICE USE ONLY:

AMOUNT_____ SERVICE FEE_____ TOTAL CHARGED_____